Dr Altman Responds

TO THE EDITOR: Thank you for the opportunity to respond to the letters concerning my Medical Staff Conference article, "Downwind Update."[1]

The role of air swallowing in the production of flatus or of symptoms of "excess" intestinal gas is at best minor. Studies by Levitt and his colleagues, cited in the October 1986 article, of the composition and volume of intestinal gas support this conclusion, especially the data that show the relatively small amount of nitrogen and large amount of carbon dioxide and hydrogen in intestinal gas. Dr Tolone points out studies supporting this concept. The important idea that the volume and composition of gas at any point are the product of multiple factors, including swallowed air, gas production, absorption and elimination, is the lesson to be derived from the illustration accompanying the article.

Dr Sommer's hypothesis that flatus retention is important in the pathogenesis of diverticular disease was first put forth by Wynne-Jones[2] but has not received general support. I believe most practitioners would be reluctant to advise patients against this practice which is probably common in so-called civilization. Certainly one must balance one's obligations to the individual patient against those to society at large. Such ethical dilemmas are beyond the scope of this author.

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2. Wynne-Jones G: Flatus retention is the major factor in diverticular disease. Lancet 1975; 2:211-212

Heparin Added to Infused Fluids

TO THE EDITOR: The article "Catheter-Related Septic Central Venous Thrombosis—Current Therapeutic Options," published in the August issue,[1] while interesting, was disappointing. The authors made no mention of the potential for prevention of this complication by a simple technique. Heparin added to infused fluids has been shown to be effective in reducing thrombosis and sepsis in indwelling catheters. In a prospective study, Fabri and colleagues[2] showed that the addition of 3,000 USP units of heparin per liter of total parenteral nutrition solution reduced the incidence of thrombosis from 31.8% to 8.3%. This was achieved without any significant difference of anticoagulation effect.

Furthermore, in a large group of morbidly obese patients undergoing gastric bypass operations (whose veins are difficult to cannulate), I have routinely added 1,000 USP units of heparin per liter of peripheral intravenous solution. This has permitted use of the original vein catheter for a full five days (when the patients start taking fluids by mouth), with a minimal incidence of phlebitis. Not only has this been less burdensome for the patients, it has saved nurses the frustration of restarting intravenous lines. It has *not* led to any complications.

It is my opinion this technique can be used safely for *all* patients requiring three to four days of parenteral feeding, as it would obviate the need to change lines every 48 hours as is routine in many hospitals.

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1. Kaufman J, Demas C, Stark K, et al: Catheter-related septic central venous thrombosis—Current therapeutic options. West J Med 1986; 145:200-203

2. Fabri PJ, Mirtallo JM, Ruberg RL, et al: Incidence and prevention of thrombosis of the subclavian vein during total parenteral nutrition. Surg Gynecol Obstet 1982; 155:238-240

Elderly Patients With Dementia

TO THE EDITOR: Dr Heikoff has done a service by again bringing forth appropriate concern for care of elderly with dementia or dementia-like syndromes.[1] In addition to underlining in her review that about 20% of elderly with dementia will have a partially or fully treatable underlying cause, further observations are in order regarding depressive, "pseudodementia."

When depression is the sole active culprit of the dementia-like syndrome, not only mood but cognitive impairment will be greatly or completely improved with successful treatment with medications or electroconvulsive therapy. Even where a presumptive early dementing syndrome, otherwise irreversible, is present, improvement of the endogenous depression will substantially improve current cognitive function. Although side effects must be viewed in context, even the presence of an actual dementing disorder should not exclude use of medicines or electroconvulsive therapy as otherwise indicated for the mood disorder.

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REFERENCE

1. Heikoff LE: Practical management of demented elderly. West J Med 1986 Sep; 145:397-399

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TO THE EDITOR: In her article "Practical Management of Demented Elderly" in the September issue,[1] Lisa Heikoff offers several suggestions that appear to me to be anything but practical. My comments below apply to the 90% of demented elderly with irreversible disease.

First, Dr Heikoff suggests that the demented patients regularly undergo routine (and presumably she means comprehensive) medical screening. Given the limited value of a digital rectal examination, should a demented patient undergo sigmoidoscopy? I think not. Would I really treat breast cancer, ovarian cancer or colon cancer in the hopelessly demented patient? Once again, I doubt it, unless the patient was suffering from symptoms secondary to these diseases, in which case I would attempt to palliate only and keep the patient comfortable.

Second, the author advocates monitoring mental status with formal psychological testing, and referral to a psychiatrist or neurologist for the same. It seems to me that these expensive tests are about as useful as counting candles on a birthday cake—decline is documented for all the world to see but nothing is materially changed.

Third, she recommends consultation with a psychiatrist or psychologist for diagnosis of depression as a contributing factor to dementia. When all is said and done, the

patient either responds favorably to an antidepressant or does not. Involving yet another care giver (a practice Dr Heikoff later decries) is hardly necessary and, once again, expensive.

Dementia is almost inexorably progressive, frustrating to treat and a terrible burden on the patient's family and no doubt on the patient. I have found that a caring family, a supportive nursing staff and the physician's willingness to advise are all that are necessary and useful. I would wonder if other primary care physicians feel the same.

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REFERENCE

1. Heikoff LE: Practical management of demented elderly. West J Med 1986 Sep; 145:397-399

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TO THE EDITOR: I have read, with interest, the article, "Features of Potentially Reversible Dementia in Elderly Outpatients" by Larson and co-workers.[1] I found the work done by the authors to be quite helpful in making the point that *all* patients with dementia, no matter their age or living status, deserve a comprehensive workup to look for potentially reversible conditions. My only exception to the authors' approach is that nowhere in the article is the value of computerized tomography (or magnetic resonance imaging) of the brain mentioned.

Computed tomography and magnetic resonance imaging of the brain are noninvasive, highly efficacious procedures in ruling out such reversible conditions as subdural hematoma, normal-pressure hydrocephalus and brain tumor. While a careful neurological history and examination are important, contemporary technology should not be ignored. True, computerized tomography and magnetic resonance imaging are relatively costly; but the long-term care often required for a patient with deteriorating mental status is far more costly, both in money and, more important, in emotional suffering by the patient and his or her family.

I think that *anyone*, young or old, who presents to a physician with organic dementia, deserves a good neurological evaluation; and that evaluation should include a computed tomographic or magnetic resonance scan of the brain.

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REFERENCE

1. Larson EB, Reifler BV, Sumi SM, et al: Features of potentially reversible dementia in elderly outpatients. West J Med 1986 Oct; 145:488-492

Side Effect of Captopril and Enalapril

TO THE EDITOR: I wish to focus *WJM* readers' attention on what appears to be a little-recognized side effect of captopril and enalapril—namely, bothersome coughing.

Reports of Cases

Two patients recently were noted with this problem in our general internal medicine practice.

The first patient, a 62-year-old woman, had been started on a regimen of enalapril maleate for the treatment of hypertension. The day following starting the drug (5 mg per day), a dry, ticklish cough developed that persisted and would awaken her in the middle of the night. This was bothersome enough to require narcotic medications prescribed by her local physician. I saw her after almost three months of this coughing problem. She had had no chest discomforts. Her lungs were clear. Pulmonary function studies showed forced vital capacity (FVC) of 2.4 (94%), and volume of gas forcefully expired in one second (FEV_1) of 2 (92%) before bronchodilator. These were unchanged after bronchodilator. The patient's medication was changed to captopril, 12.5 mg twice a day, and her coughing continued. The coughing did not clear until captopril therapy was also discontinued.

The second patient, a 76-year-old woman with hypertension, was started on a regimen of enalapril, 2.5 mg per day. Very shortly thereafter, she began noting a dry mouth and persistent ticklish cough without sputum production. This kept her awake at night. After four months of this, her medication was changed to captopril, 25 mg twice a day, in place of the enalapril. Her symptoms resolved completely and she was able to continue with captopril without difficulty.

Discussion

In the *Physicians' Desk Reference,* cough is mentioned as an uncommon side effect of enalapril. Dry mouth and dyspnea are listed as possible side effects of captopril but cough is not mentioned.

I believe that readers should be aware of coughing as a potential side effect of these medications. The two medications may or may not cross-react with each other in this regard. Awareness of this potential problem may help avoid lengthy diagnostic workups that may otherwise be unnecessary.

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Correction: Diagnostic Immunopathy

TO THE EDITOR: It has been brought to my attention that a manuscript mistake resulted in an error in Table 3 in the UCLA Specialty Conference in the July issue.[1] In that table (page 71) the marker studies for chronic leukemia appeared twice (redundant) and there is a mistake in the repeated part (11B4 should be corrected to B4).

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REFERENCE

1. Cancilla PA, Cochran AJ, Naeim F, et al: Diagnostic immunopathology (Specialty Conference). West J Med 1986 Jul; 145:65-73